STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105602	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hawthorne Center for Rehabilitation and Healing Of	4100 SW 33rd Ave Ocala, FL 34474

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, and review of policy and procedures, the facility failed to ensure residents with prescribed controlled medications were administered the medications per the physician order when failing to contact the physician when prescriptions were needed and the medications were not administered for three of three residents reviewed for medication administration (Residents #7, #9, and #10). Resident #7, with a history of prescribed Alprazolam use, was admitted into the facility on 6/11/2025 and had been prescribed Alprazolam four times a day. Resident #7 suffered withdrawal symptoms of sweating, shaking, insomnia, and increased pain. There was a delay in administering Alprazolam until 6/13/2025 at 9:00 PM resulting in nine missed doses. Resident #9, with a history of prescribed Alprazolam use, was admitted into the facility on 5/20/2025 and was prescribed Alprazolam once a day. Resident #9 was not administered Alprazolam until 5/24/2025 resulting in three missed doses. Resident #10, a long-time resident of the facility, with a history of prescribed Alprazolam use, was prescribed Alprazolam twice a day and missed three doses. Abruptly stopping Alprazolam can be dangerous and lead to a range of severe, potentially life-threatening complications. These dangers can include tremors and seizure, nausea, vomiting, diarrhea, muscle pain and stiffness, heart palpitations, headaches, irritability and agitation, confusion and delirium, hallucinations and psychosis, and suicidal thoughts or actions. The facility's failure to implement the policy and procedures for medication administration and failure to ensure residents who required Alprazolam received treatment in accordance with professional standards of practice led to a determination of Immediate Jeopardy at a scope and severity of pattern (K). The Nursing Home Administrator was notified of the Immediate Jeopardy on June 17, 2025, at 4:44 PM. Findings include: Review of the admission Record for Resident #9 documented an admission date of 5/20/2025 with medical diagnoses that include anxiety disorder unspecified, depression unspecified, essential (primary) hypertension (high blood pressure), unspecified fracture of right pubis (break in the bone of the pelvis) subsequent encounter for fracture with routine healing, fall on same level from slipping tripping and stumbling without subsequent striking against object subsequent encounter, gastroesophageal reflux disease without esophagitis, and chronic obstructive pulmonary disease unspecified. Review of hospital Discharge summary dated [DATE] for Resident #9 read, New medications included Alprazolam 0.5 mg (milligrams) daily next dose tomorrow (05/21/25) morning. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #9's physician orders dated 5/20/2025 read, Alprazolam Oral Tablet 0.5 MG (milligram) Give 1 tablet by mouth in the morning for anxiety. Review of Resident #9's May medication administration record (MAR) on 5/21, 5/22 and 5/23/2025, Alprazolam was documented as 9 [chart code for other/see nurses notes]. Review of Resident #9's progress notes from 5/20/2025 through 5/23/2025, documented no progress notes related to Alprazolam and no notification to the physician that the medication was unavailable. Review of Resident #9's Specialty Rx [a symbol that primarily refers to a prescription in the medical context] form titled, Medication Monitoring/Control Record, with a date received as 5/23/2025 documented the first dose of Alprazolam administered to Resident #9 was on 5/24/2025 at 0900 [9:00 AM]. Review of Resident #9's comprehensive care plan with an implementation date of 5/20/2025 read, Focus: [Resident #9's name] uses anti-anxiety medications. Goal: The resident will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date. Interventions: Administer anti-anxiety medications as ordered by physician. Monitor for side effects and effectiveness Q (every) shift. During an interview on 6/16/2025 at 10:13 AM, Resident #9 stated, I do take medication for my anxiety. I am getting my medicine now, but when I was first admitted , it took a long time for them to get it. I think it was three days before they got it from the pharmacy. They [the nurses] kept saying they were waiting on the pharmacy. I don't really know why it would take so long, they knew I was coming, and they knew what I needed to take when I got here. It is upsetting to think they can't get the medicines you need. During an interview on 6/16/2025 at 11:30 AM, Staff A, Licensed Practical Nurse (LPN) stated, I did take care of [Resident #9's name] and I did not give her the Alprazolam on 5/23, it wasn't in yet. I do think I called and made sure it was ordered. I think I called the pharmacy. I didn't know that we could get it out of the [name of the automated medication dispensing system]. During an interview on 6/16/2025 at 1:30 PM, the Advanced Practice Registered Nurse (APRN) stated, I was not notified that [Resident #9's name] did not receive her Xanax [Alprazolam] when she was admitted . I'm not sure why that happened. It should not take three days to receive medication for a resident. She [Resident #9] would be at risk for withdrawal symptoms. This is a problem that nurses are not aware of what is available to them and what they need to do. During an interview on 6/17/2025 at 7:30 AM, Staff C, LPN stated, I was not aware that there was Alprazolam in the [name of the automated medication dispensing system] machine. I did not give her [Resident #9] her Alprazolam, it was ordered, and a prescription had been sent to pharmacy, so we were just waiting for it to get in. 2. Review of the admission Record for Resident #10 documented an admission date of 8/27/2024 with medical diagnoses that include chronic obstructive pulmonary disease unspecified, major depressive disorder recurrent unspecified, peripheral vascular disease (reduced circulation of blood to a body part) unspecified, atherosclerotic heart disease of native coronary arteries (heart disease) without angina pectoris (chest pain), essential (primary) hypertension, anxiety disorder unspecified, and other chronic pain. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #10's physician orders dated 5/26/2025 read, Alprazolam Oral Tablet 0.5 MG (milligram) Give 1 tablet by mouth every 12 hours for Anxiety. Review of Resident #10's May MAR, Alprazolam was documented as 9 [chart code for other/see nurses notes] for 5/31/2025 at 2100 [9:00 PM]. Review of Resident #10's Specialty Rx form titled, Medication Monitoring/Control Record documented the last dose of Alprazolam 0.5 mg was administered to Resident #10 on 5/31/2025 at 9:21 AM. Review of Resident #10's June MAR Alprazolam 0.5 mg documented as 9 [chart code for other/see nurses notes] for 6/1/2025 at 0900 [9:00 AM] and 2100 [9:00 PM]. Review of Resident #10's Specialty Rx form titled Medication Monitoring/Control Record, date received 6/2/25 documented the next dose of Alprazolam 0.5 mg was administered to Resident #10 on 6/2/2025 at 0900 (9:00 AM). Review of Resident #10's progress notes from 5/31/2025 through 6/4/2025, documented no progress notes related to Alprazolam and no notification to the physician that the medication was unavailable. During an interview on 6/17/2025 at 7:30 AM, Staff C, LPN stated, I did not give [Resident #10's name] her Alprazolam either. I did call pharmacy on her [Resident #10], and they needed a prescription, and I think I called and got it. Like I told you, I had no idea we could get it from the [name of the automated medication dispensing system]. 3. Review of the admission Record for Resident #7 documented an admission date of 6/11/2025 with medical diagnoses that include fracture of superior rim of right pubis, subsequent encounter for fracture with routine healing, unspecified fracture of sacrum, subsequent encounter for fracture with routine healing, unstable burst fracture of T5-T6 [thoracic, upper back between the neck and lumbar spine] vertebra, subsequent encounter for fracture with routine healing, unspecified injury of head, subsequent encounter, unspecified fracture of T11-T12 vertebra, chronic obstructive pulmonary disease with (acute) exacerbation, peripheral vascular disease, unspecified, age-related osteoporosis without current pathological fracture, chronic systolic (congestive) heart failure, unspecified osteoarthritis, unspecified site, acute and chronic respiratory failure with hypoxia, hypothyroidism, unspecified, displaced fracture of base of neck of right femur, subsequent encounter for closed fracture with routine healing, diverticulitis of both small and large intestine without perforation or abscess without bleeding, nondisplaced comminuted [type of bone fracture where the bone breaks in three or more pieces] fracture of shaft of humerus, right arm, subsequent encounter for fracture with routine healing, essential (primary) hypertension, atherosclerotic heart disease of native coronary artery without angina pectoris, unspecified fracture of unspecified thoracic vertebra, sequela, unspecified fracture of first lumbar vertebra, sequela, hyperlipidemia, unspecified, iron deficiency anemia secondary to blood loss (chronic), personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits, anxiety disorder, unspecified, personal history of other venous thrombosis and embolism, and chronic atrial fibrillation, unspecified. Review of the hospital Discharge summary dated [DATE] for Resident #9 read, Continued Medications: 8. Alprazolam 1 mg oral four times a day. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #7's physician orders dated 6/11/2025 read, Alprazolam Oral Tablet 1 MG Give 1 tablet by mouth four times a day for anxiety. Review of Resident #7's June MAR Alprazolam 1 mg was documented as 9 [chart code other/see nurses notes] on 6/11/2025 at 1700 [5:00PM], 2100 [9:00 PM], on 6/12/2025 at 0900, 1200, 1700 [5:00 PM] and 2100 [9:00 PM], on 6/13/2025 at 0900, 1200, and 1700. Review of Resident #7's Specialty Rx form titled, Medication Monitoring/Control Record documented that Alprazolam tab 1 mg 1 tablet by mouth four times daily for 30 days was received at the facility on 6/13/2025. The first dose of Alprazolam 1 mg was administered to Resident #7 on 6/13/2025 at 2100 [9:00 PM]. A total of nine doses were not administered. Review of Resident #7's progress notes from 6/11/2025 through 6/14/2025, documented no progress notes related to Alprazolam and no notification to the physician that the medication was unavailable. During an observation on 6/15/2025 at 1:20 PM, Resident #7's spouse was assisting her with meal at bedside. An interview with the spouse, [Resident Representative's name] stated It took them four days to get a medication she has taken for years. She takes Xanax [Alprazolam] 1 mg 4 times a day and they didn't give it to her. She was just having a terrible time, sweating, shaking, not sleeping good, and having just an awful time of it. Her pain was worse, and she wouldn't let them do things to her. I tried telling them, but they wouldn't listen. She has taken this medication for years now. During an interview on 6/15/2025 at 1:30 PM, Resident #7 stated, I was feeling awful, in so much pain, sweating, aching all over and just couldn't do anything because I felt so awful. I asked everyday about my medication, and they just told me it wasn't here. I felt awful, I think I was more anxious, couldn't sleep right, was sweaty and miserable. I did start feeling better after I got the medication. It came and I think it was four days before they got it, but I can't say for sure now. It was the one nurse here for a few days, she just kept saying pharmacy hadn't sent it. I don't know why they didn't have it. Then one day they told me the doctor needed to order it, but I was taking it in the hospital. I know I have a lot of broken bones, but when I didn't get the medicine, I feel like I was in a lot more pain, everything hurt worse. I asked every nurse when they gave medicine where it was and how long before it got here, none of them could say. I don't understand why they didn't get the medicine. I don't understand why the pharmacy doesn't deliver medicine faster. They should have made sure the prescription was there when I first got here. I can't understand why they [the nurses] didn't call for the prescription sooner, why did it take so long. I asked every time a nurse came in if my medicine was here yet. They did not care or really listen to me. They should make sure that medicine is here when someone is admitted . We told the nurses every day. During an interview on 6/15/2025 at 1:58 PM, the Director of Nursing (DON) stated, It is a standard of care that nurses call the doctors and let them know that medications are not available to administer. The staff should have called the doctor and documented that in the chart. The 9 chart code is other/see nurses notes. There are no notes in the chart telling me why the [Alprazolam] wasn't given. I don't think we have policies for med [medication] administration that state when to call the doctor, that is a standard if residents refuse or meds [medications] are not available, we give them [the physician] a call. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 6/16/2025 at 10:45 AM, the DON stated, The process is that we admit patients and fax the prescriptions to pharmacy from the hospital, sometimes they don't come with the resident, and we will need to call the doctor or nurse practitioner and have them provide a prescription to the pharmacy. This was not done for her [Resident #7], they did not call the provider until the 13th, they should have. I don't know if it is available in the EDK (Emergency Drug Kit) [also known as the automated medication dispensing system]. During an observation on 6/16/2025 at 10:45 AM, with the DON and the Administrator of the supply room where the automated medication dispensing machine was located, there was a printed handout that provided a list of all medications that were available to be taken from the machine. On page one of the document titled, [the name of the automated medication dispensing system] inventory is Alprazolam 0.25 mg Par [periodic automatic replenishment] 20. During an interview on 6/16/2025 at 10:45 AM, the DON stated, Well, the [Alprazolam] were in the [name of the automated medication dispensing system] and we should have been able to call the provider, get a script (prescription) and then call pharmacy for the code to administer the medication. The [Alprazolam] were available the entire time she [Resident #7] went without them. I guess the nurses did not know they were available for them [Residents #7, #9, and #10]. Each nurse should have called the doctor or nurse practitioner, asked them to get a script to pharmacy and asked pharmacy to let them get the med (medication) from the [name of the automated medication dispensing system]. I guess they all need training on everything that's available in it [the automated medication dispensing system]. I was not aware that this was happening, none of the nurses came to me or a supervisor and let them know about this. It is a professional standard of practice to notify a doctor when medication can't be administered. I will have to check, but I don't think anyone documented that they did any type of notification to a doctor or nurse practitioner. During an interview on 6/16/25 at 11:30 AM, Staff A, LPN stated, I called [the pharmacy] on the 13th to get her [Resident #7] medication. I didn't know that Xanax [Alprazolam] was available in the machine at that time. We are supposed to notify the doctor when we are unable to administer any medications. We need to let the doctor know with one missed dose. I did not call the doctor or nurse practitioner. I didn't know what was in the machine [the automated medication dispensing system] or that narcotics were in there. When we don't have a medicine we need to get a script (prescription) and call the pharmacy to get an authorization code to get the medicine. She didn't complain about anything to me except not having the medicine for a few days. Her husband was there [on 6/13] and he did say, she needs it she takes it all the time and she's hurting without it. I explained that I needed to get the prescription from the doctor and there wasn't anything I could do until I got the prescription and sent it. I feel badly; I really don't know anything about the withdrawal symptoms. I don't think that [what is available in the automated medication dispensing system] was covered when I oriented. I don't think they went over what was in the machine [the automated medication dispensing system].I did not document in the progress notes that I couldn't administer the medication. I really should have done that. I did not call pharmacy every day or with every dose she missed, I should have. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 6/16/2025 at 1:30 PM, the APRN stated, I was called on I think it was the 13th for a prescription for her [Resident #7] Xanax (Alprazolam). I can't tell you exactly when she [the nurse] contacted me. I think that some of the problems are the hospitals sometimes don't send prescriptions with the patients when they get discharged . I do think I should have been contacted for both of the patients [Resident #7 and #9] when they couldn't administer the medications when ordered. [Resident #7's name] has taken 1 mg of Xanax for a long time. She could have had withdrawal symptoms starting within the 24 hours, irritability, sweating, sleeplessness, heightening pain and discomfort. There absolutely is the risk of withdrawal with abrupt stopping of benzodiazepines [a class of central nervous system depressants used to treat anxiety, insomnia and seizures]. She would likely, most people would likely, begin to feel the effects within 24 hours and it would worsen. There is a likelihood of a seizure. It would be harmful for anyone who was on benzodiazepines to suffer withdrawal when they aren't administered the medication and abruptly stopped. They should have called me. I would have provided the pharmacy with the script. I would not know what is in the [name of the automated medication dispensing system], but if Xanax is in it I could have provided a script for a limited number of doses until the correct dose was available from pharmacy. I would say that anyone could possibly suffer harm from this [not being administered Alprazolam]. I do expect to be notified if nursing can't administer ordered medications, if vitals are abnormal and meds don't have parameters. I want to be notified with any changes in the resident's condition. This is a problem that nurses are not aware of what is available to them and what they need to do. During an interview on 6/17/2025 at 7:10 AM, Staff B, LPN stated, I took care of [Resident #7's name] and did not have the medication to administer on the night of her admission. I was waiting on the medication to get here. I can't remember but I think I called pharmacy that night and they said they were working on getting her meds (medications) in. I have been a nurse for a long time, and I know each place has an EDK [Emergency Drug Kit], whether it's a [name of the automated medication dispensing system] or a box. But I didn't realize we should call and get another one-time order for the medication. I should have done that. I didn't know that we could get the Xanax [Alprazolam]. I did not get any orders and did not call the pharmacy or the nurse practitioner. During an interview on 6/17/2025 at 7:30 AM, Staff C, LPN stated, I did not do any medication orders for her [Resident #7], that was completed by another staff, [Staff E, LPN's name], on the day she was admitted . I got involved when my father [Staff C is Resident #7's daughter] came and told me she still didn't have her medication. He told me this every day and finally on the 13th I found out it was because she didn't have a prescription with the pharmacy, and I called [APRN's name] and got that taken care of. She [Resident #7] has been taking this medication for at least eight years now, at that dose and really she is dependent on it. I do think she [Resident #7] was experiencing withdrawal symptoms. Finally on the 13th at some time she finally got the medicine. I don't take direct care of her ever and I try not to interfere with her [Resident #7] care, but I needed to make sure she had her medicine. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 6/17/2025 at 8:47 AM, the Registered Pharmacist, RPhD [doctorate] stated, We receive orders and e [electronic] scripts daily for all residents from this facility. All prescribers have access to Escribe [an electronic record to prescribe medications electronically] and can send orders at any time of the day and night. Typically, medications will go out at 2 PM and 2 AM but the facilities can ask for a stat [Latin word STATim which translates to immediately] run at any time. If the orders are received prior to 1-1:30 PM, they will go out with the afternoon run and will be at the facility between 5-7 PM depending on traffic and if received prior to 1:30 AM, it would arrive between 5-7 AM. We do have Alprazolam on PAR (periodic automatic replacement) in the [name of the automated medication dispensing system]. I can't say for sure, but I think it's a PAR of 20 at all times. I would say there is a huge problem if this medication is stopped abruptly, a large risk of withdrawal, this would begin with 16-24 hours after the last dose and would continue up to 5-10 days and with extended use, people can have a longer more extensive withdrawal time. Most commonly people develop nausea, vomiting, restlessness, irritability, agitation sleep disturbances, shakes and tremors. The most severe would be seizures and that generally occurs with higher doses at longer duration of exposure. At 1 mg four times a day it is likely that the patient began to experience one or more of these symptoms. I would say that withdrawal is not physically or mentally comfortable. The medication was always available to be administered to the patient until her medication arrived had someone called and notified us that she did not have the medication. We could have told them that we needed the prescription before the 13th. During an interview on 6/17/2025 at 9:11 AM, Staff D, LPN stated, I didn't realize that we could pull the medicine from the machine [the automated medication dispensing system]. I didn't know it [Alprazolam] was in there. I just thought it was like antibiotics and things like that. I should have asked someone about it. I should have called the doctor to get more orders, and I didn't. During an interview on 6/17/2025 at 9:50 AM, the Medical Director stated, I am the Medical Director and have been notified of the concerns that you have brought. I understand this impacted three residents, one taking Xanax once a day, one twice a day, and one four times a day. We do have some concerns with really newly admitted patients not coming with prescriptions for medications and here with some on-call providers not being able to escribe meds. But as Medical Director I am always available. There would be concerns with stopping this [Alprazolam] for long periods of time. We have more problems with opioids and returning patients to hospital because they have not come with a prescription and a provider who doesn't want to prescribe without first seeing the patient. I think this was caused when the nurses did not know that it [Alprazolam] was available and is always available. I am not their doctor so I can't really say if it would have caused any harm. During an interview on 6/17/2025 at 11:17 AM Staff E, LPN stated, I didn't actually do anything with [Resident #7's name] except fax the orders to pharmacy. I didn't see a prescription for the Xanax [Alprazolam] and the nurse coming on, I told that to her. I told her that I didn't do that [send the order for Xanax [Alprazolam]]. I did not call the nurse practitioner for the prescription. I did not know that the medication was in the [name of the automated dispensing system] machine. I don't remember any training on that. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 6/17/2025 at 3:05 PM, the DON stated, I should have been more involved and made sure that the nurses were aware of the process. I handed this to the Educator, who no longer works here, and I should have made sure that all staff were trained. It is my responsibility. No one told me that anyone had concerns about their medications. I do not audit medication administration. I just wasn't aware that this was a concern. I do expect all staff to follow doctor's orders for medications and call when they cannot give the med [medication]. Staff should all know what medications are available to them in the [name of the automated medication dispensing system]. During an interview on 6/17/2025 at 3:30 PM, the Administrator stated, Well, I would have to defer any nursing questions to the Director of Nursing, I am not clinical. Ultimately, I do expect staff to follow the policies and procedures for medication administration and any other we have. Review of the policy and procedure titled Medication Administration General Guidelines last approval date of 01/2025 read, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling and administration). The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions. Procedure: A. Preparation . 11.) If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (e.g.,) are searched , if possible. If the medication cannot be located after further investigation, the pharmacy is contacted or medication removed from the night box/emergency kit. B. Administration .2) Medications are administered in accordance with written orders of the prescriber 6) Medications are administered without unnecessary interruptions. D. Documentation (including electronic) .6) If a dose of regularly scheduled medication is withheld, refused, not available or given at a time other than the scheduled time (e.g., the resident is not in the facility at scheduled dose time, or a starter dose of an antibiotic is needed), the space provided in [name of clinical software] is coded with appropriate code. An explanatory note is entered in nurses notes/progress note. If a dose of vital medication are withheld, refused, or not available the physician is notified. Nursing documents the notification and physician response. (continued on next page)

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Hawthorne Center for Rehabilitation and Healing Of	4100 SW 33rd Ave Ocala, FL 34474

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Immediate Jeopardy (IJ) was removed onsite on June 17,2025 after the receipt of an acceptable IJ removal plan. The facility has completed the following steps to remove the immediate jeopardy. On June 17, 2025, an Ad Hoc [Latin meaning 'for this'] QAPI [Quality Assurance and Performance Improvement] was completed in the presence of the Nursing Home Administrator, the Director of Nursing, and the Medical Director to identify the root cause analysis. It was determined that the facility failed to ensure residents were free from medication errors and missed controlled prescription medications when facility staff did not know what was available in the [name of the automated medication dispensing system]. A performance improvement plan was developed and implemented for medication management and clinical communication processes. On June 17, 2025 the Director of Nursing developed a 'Missed Dose Escalation Protocol' that requires immediate notification to the charge nurse and Director of Nursing if any scheduled medication that is not administered and documentation of physician notification within one hour. On June 17, 2025, 47 of 47 licensed staff received training and education on medication administration, [name of the automated medication dispensing system] medication availability, location of the [name of the automated medication dispensing system] inventory sheets, staff [name of the automated medication dispensing system] log in, following physician orders, Missed Dose Escalation Protocol and medical doctor and family notification. On June 17, 2025, the Director of Nursing completed a full house audit of all residents receiving Alprazolam. On June 17,2025, the Regional Director of Clinical Services reviewed the facility medication administration policy and procedures and changes were made to include steps for medication escalation protocol, procedures to address missed doses, notification requirements and documentation requirements for missed doses. On June 17, 2025, the Regional Director of Operations provided training and education to the Administrator, Director of Nursing, Unit Manager and assistant Director of Nursing on facility administration, job descriptions, on medication administration, [name of the automated medication dispensing system] medication availability, location of the [name of the automated medication dispensing system] inventory sheets, staff [name of the automated medication dispensing system] log in, following physician orders, missed dose escalation protocol and medical doctor and family notification. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility records documented that there were seven residents receiving Alprazolam and the additional four residents had no concerns with medication administration and no missed doses. Review of the facility records beginning 6/16/2025 and completed on 6/17/2025 documented that 47 out of 47 licensed nursing staff received training and education on medication administration, [name of the automated medication dispensing system] medication availability, location of the [name of the automated medication dispensing system] inventory sheets, staff [name of the automated medication dispensing system] log in, following physician orders, missed dose escalation protocol and medical doctor and family notification. Review of the facility records dated 6/17/2025 documented that four out of four administrative staff received training and education on facility administration, job descriptions, on medication administration, [name of the automated medication dispensing system] medication availability, location of the [name of the automated medication dispensing system] inventory sheets, staff [name of the automated medication dispensing system] log in, following physician orders, missed dose escalation protocol and medical doctor and family notification. Review of the policy and procedure titled Medication Administration General Guidelines updated on 6/17/2025, read, If a dose of regularly schedule medication is withheld, refused, not available, or given at a time other than scheduled time (e.g., the resident is not in the facility at scheduled dose time, or a starter dose of an antibiotic is needed) the space provided in [name of the electronic medical record software] is coded with appropriate code. An explanatory note is entered in the nurses/note/progress note. If a dose of medication is refused the physician is notified. If dose of a medication is withheld or not available the Missed Dose Escalation Protocol will be followed. The protocol includes the following information. The DON and physician are notified. The physician will determine if the medication is needed to be provided at the time. In the event the medication is required the nurse will retrieve medication from the emergency medication dispensing system. In the event the medication is a controlled substance, the nurse will contact pharmacy to ask to obtain the medication from the emergency medication dispensing system. If the medication is not available in the emergency medication dis[TRUNCATED]

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, and review of policies and procedures, the facility administration failed to administer the facility in a manner that enables it to use its resources effectively and efficiently to attain and maintain the highest practicable physical wellbeing of each resident by failing to implement policy and procedures for medication administration. The facility failed to ensure residents with prescribed controlled medications were administered the medications per the physician order when failing to contact the physician when prescriptions were needed and the medications were not administered for three of three residents reviewed(Residents #7, #9, and #10). Resident #7, with a history of prescribed Alprazolam use, was admitted into the facility on 6/11/2025 and had been prescribed Alprazolam four times a day. Resident #7 suffered withdrawal symptoms of sweating, shaking, insomnia, and increased pain. There was a delay in administering Alprazolam until 6/13/2025 at 9:00 PM resulting in nine missed doses. Resident #9, with a history of prescribed Alprazolam use, was admitted into the facility on 5/20/2025 and was prescribed Alprazolam once a day. Resident #9 was not administered Alprazolam until 5/24/2025 resulting in three missed doses. Resident #10, a long-time resident of the facility, with a history of prescribed Alprazolam use, was prescribed Alprazolam twice a day and missed three doses. The facility's failure to implement the policy and procedure for medication administration to ensure residents who required Alprazolam received treatment in accordance with professional standards of practice led to a determination of Immediate Jeopardy at a scope and severity of pattern (K). The Nursing Home Administrator was notified of the Immediate Jeopardy on June 17, 2025, at 4:44 PM. Findings include: Review of the document titled, Nursing Home Job Description Administrator, read, Job function: responsible for directing the overall operation of the facility's activities with current federal, state, local and corporate standards, guidelines and regulations ensuring the highest degree of quality resident care is provided at all times. Supervises: Department Heads and Office staff. Primary Responsibilities: 1. Assure that the goals of the Nursing Home are being met-the provision of quality resident care in a highly respectful, highly regulated, well managed, and caring environment and billing and collection for these services. 2. Complete other duties as assigned by supervisor. Specific Duties: .4. Personnel b. Participate in orientation training program for new employees and monitor training including, but not limited to, OJT (on the job training), and in-services. C. Monitor staff training period for all employees. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the document titled, Nursing Home Job Description Director of Nursing, read, Job Function: coordinate and direct all health care services provided to the Resident. Supervises: Shift Coordinators, CNA's (Certified Nursing Assistants), MDS (minimum data set) Coordinators, Shift Nurses, Medical Services, Medical Records, Pharmacist. Report to: Administrator. Primary responsibilities: 1. Implement and monitor facility policies and procedures to ensure that the facility is in compliance with all Federal and State Minimum Standards as they apply to nursing and medical services. 3. Supervise all documentation of services provided to residents. 9. Interview, hire, train and supervise all employees under your supervision and review staff competency in dealing with medical issues and provide training on a regular and as needed basis. 10. Perform other duties as assigned by the Administrator. Specific duties: 2. Final responsibility for interviewing, hiring, scheduling and supervising all staff that work under your supervision .18. Spot check all nurses' documentation by randomly auditing charts daily. 19. Coordinate review of Physician Order Sheets on a monthly basis for accuracy. 21. Monitor eMAR (electronic Medication Administration Record) compliance reports, routinely observe medication administration. Investigate medication errors and follow up with any corrective action. Review of the document titled, Medical Director Services Agreement, read, Recitals: Now therefore, in consideration of the covenants and agreements herein contained and the moneys to be paid here under, the parties agree upon the following terms and conditions: 3 Medical Director of Facility: During the term, Physician agrees to serve as Medical Director for Facility. Physician agrees to perform the services identified on Exhibit A attached hereto and incorporated herein by reference. Exhibit A: Associate Medical Director Services: Physician shall provide these services in conjunction with the Facility Medical Director and Facility. 2. Develop, implement, and evaluate resident care policies, procedures and guidelines, based on the current standards of practice, and collaborate with Facility leadership, including the Facility Medical Director, staff, and other practitioners and consultants regarding the following: b. accidents and incidents, use of medications, use and release of clinical information, ancillary services such as laboratory, radiology, and pharmacy and overall quality of care. d. the safe and effective use of medications to meet the needs of residents, j. the contents of the Facility's emergency medication kit and k. medical and clinical concerns and issues that affect resident care, medical care, or quality of life, or are related to the provision of services by physicians or other licensed health care practitioners. 5. Advise and consult with the Facility Administrator and Medical Director regarding: a. Facility's ability to meet the residents' needs and opportunities for future resident care programs, b. the adequacy and appropriateness of Facility's scope of services, medical equipment, and its professional and support staff; d. the staffing, operational, and other needs of the facility; 6. Direct and Coordinate: a. the medical care in Facility and ensure Facility is providing appropriate care as required; e. In-service education by providing information for Facility personnel as may be required by accrediting bodies and facility, including pertinent education regarding existing and proposed procedures within Facility. Review of the admission Record for Resident #9 documented an admission date of 5/20/2025 with medical diagnoses that include anxiety disorder unspecified, depression unspecified, essential (primary) hypertension (high blood pressure), unspecified fracture of right pubis (break in the bone of the pelvis) subsequent encounter for fracture with routine healing, fall on same level from slipping tripping and stumbling without subsequent striking against object subsequent encounter, gastroesophageal reflux disease without esophagitis, and chronic obstructive pulmonary disease unspecified. Review of hospital Discharge summary dated [DATE] for Resident #9 read, New medications included Alprazolam 0.5 mg (milligrams) daily next dose tomorrow (05/21/25) morning. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #9's physician orders dated 5/20/2025 read, Alprazolam Oral Tablet 0.5 MG (milligram) Give 1 tablet by mouth in the morning for anxiety. Review of Resident #9's May medication administration record (MAR) on 5/21, 5/22 and 5/23/2025 Alprazolam is documented as 9 [chart code for other/see nurses notes]. Review of Resident #9's progress notes from 5/20/2025 through 5/23/2025, documented no progress notes related to Alprazolam and no notification to the physician that the medication was unavailable. Review of Resident #9's Specialty Rx [a symbol that primarily refers to a prescription in the medical context] form titled, Medication Monitoring/Control Record, with a date received as 5/23/2025 documented the first dose of Alprazolam administered to Resident #9 was on 5/24/2025 at 0900 [9:00 AM]. Review of Resident #9's comprehensive care plan with an implementation date of 5/20/2025 read, Focus: [Resident #9's name] uses anti-anxiety medications. Goal: The resident will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date. Interventions: Administer anti-anxiety medications as ordered by physician. Monitor for side effects and effectiveness Q (every) shift. During an interview on 6/16/2025 at 10:13 AM Resident #9 stated, I do take medication for my anxiety. I am getting my medicine now, but when I was first admitted , it took a long time for them to get it. I think it was three days before they got it from the pharmacy. They [the nurses] kept saying they were waiting on the pharmacy. I don't really know why it would take so long, they knew I was coming, and they knew what I needed to take when I got here. It is upsetting to think they can't get the medicines you need. During an interview on 6/16/2025 at 11:30 AM, Staff A, Licensed Practical Nurse (LPN) stated, I did take care of [Resident #9's name] and I did not give her the Alprazolam on 5/23, it wasn't in yet. I do think I called and made sure it was ordered. I think I called the pharmacy. I didn't know that we could get it out of the [name of the automated medication dispensing system]. During an interview on 6/16/2025 at 1:30 PM the Advanced Practice Registered Nurse (APRN) stated, I was not notified that [Resident #9's name] also did not receive her Xanax [Alprazolam] when she was admitted . I'm not sure why that happened. It should not take three days to receive medication for a resident. She [Resident #9] would be at risk for withdrawal symptoms. This is a problem that nurses are not aware of what is available to them and what they need to do. During an interview on 6/17/2025 at 7:30 AM Staff C, LPN stated, I was not aware that there was Alprazolam in the [name of the automated medication dispensing system] machine. I did not give her [Resident #9] her Alprazolam, it was ordered, and a prescription had been sent to pharmacy, so we were just waiting for it to get in. 2. Review of the admission Record for Resident #10 documented an admission date of 8/27/2024 with medical diagnoses that include chronic obstructive pulmonary disease unspecified, major depressive disorder recurrent unspecified, peripheral vascular disease (reduced circulation of blood to a body part) unspecified, atherosclerotic heart disease of native coronary arteries (heart disease) without angina pectoris (chest pain), essential (primary) hypertension, anxiety disorder unspecified, and other chronic pain. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #10's physician orders dated 5/26/2025 read, Alprazolam Oral Tablet 0.5 MG (milligram) Give 1 tablet by mouth every 12 hours for Anxiety. Review of Resident #10's May MAR, Alprazolam was documented as 9 [chart code for other/ see nurses notes] for 5/31/2025 at 2100 [9:00 PM]. Review of Resident #10's Specialty Rx form titled, Medication Monitoring/Control Record documented the last dose of Alprazolam 0.5 mg was administered to Resident #10 on 5/31/2025 at 9:21 AM. Review of Resident #10's June MAR alprazolam 0.5 mg documented as 9 [chart code other see nurses] for 6/1/2025 at 0900 [9:00 AM] and 2100 [9:00 PM]. Review of Resident #10's Specialty Rx form titled Medication Monitoring/Control Record date received of 6/2/25 documented the next dose of Alprazolam 0.5 mg was administered to Resident #10 on 6/2/2025 at 0900 (9:00 AM). Review of Resident #10's progress notes from 5/31/2025 through 6/4/2025, documented no progress notes related to Alprazolam and no notification to the physician that the medication was unavailable. During an interview on 6/17/2025 at 7:30 AM, Staff C, LPN stated, I did not give [Resident #10's name] her Alprazolam either. I did call pharmacy on her [Resident #10], and they needed a prescription, and I think I called and got it. Like I told you, I had no idea we could get it from the [name of the automated medication dispensing system]. 3. Review of the admission Record for Resident #7 documented an admission date of 6/11/2025 with medical diagnoses that include fracture of superior rim of right pubis, subsequent encounter for fracture with routine healing, unspecified fracture of sacrum, subsequent encounter for fracture with routine healing, unstable burst fracture of T5-T6 [thoracic, upper back between the neck and lumbar spine] vertebra, subsequent encounter for fracture with routine healing, unspecified injury of head, subsequent encounter, unspecified fracture of T11-T12 vertebra, chronic obstructive pulmonary disease with (acute) exacerbation, peripheral vascular disease, unspecified, age-related osteoporosis without current pathological fracture, chronic systolic (congestive) heart failure, unspecified osteoarthritis, unspecified site, acute and chronic respiratory failure with hypoxia, hypothyroidism, unspecified, displaced fracture of base of neck of right femur, subsequent encounter for closed fracture with routine healing, diverticulitis of both small and large intestine without perforation or abscess without bleeding, nondisplaced comminuted [type of bone fracture where the bone breaks in three or more pieces] fracture of shaft of humerus, right arm, subsequent encounter for fracture with routine healing, essential (primary) hypertension, atherosclerotic heart disease of native coronary artery without angina pectoris, unspecified fracture of unspecified thoracic vertebra, sequela, unspecified fracture of first lumbar vertebra, sequela, hyperlipidemia, unspecified, iron deficiency anemia secondary to blood loss (chronic), personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits, anxiety disorder, unspecified, personal history of other venous thrombosis and embolism, and chronic atrial fibrillation, unspecified. Review of hospital Discharge summary dated [DATE] for Resident #9 read, Continued Medications: 8. Alprazolam 1 mg oral four times a day. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #7's physician orders dated 6/11/2025 read, Alprazolam Oral Tablet 1 MG Give 1 tablet by mouth four times a day for anxiety. Review of Resident #7's June MAR Alprazolam 1 mg documented as 9 [chart code other/see nurses notes] on 6/11/2025 at 1700 [5:00PM], 2100 [9:00 PM], on 6/12/2025 at 0900, 1200, 1700 [5:00 PM] and 2100 [9:00 PM], on 6/13/2025 at 0900, 1200, and 1700. Review of Resident #7's Specialty Rx form titled, Medication Monitoring/Control Record documented that Alprazolam tab 1 mg 1 tablet by mouth four times daily for 30 days was received at the facility on 6/13/2025. The first dose of Alprazolam 1 mg was administered to Resident #7 on 6/13/2025 at 2100 [9:00 PM]. A total of nine doses were not administered. Review of Resident #7's progress notes from 6/11/2025 through 6/14/2025, documented no progress notes related to Alprazolam and no notification to the physician that the medication was unavailable. During an observation on 6/15/2025 at 1:20 PM, Resident #7's spouse was assisting her with meal at bedside. An interview with the spouse, [Resident Representative's name] stated It took them four days to get a medication she has taken for years. She takes Xanax [Alprazolam] 1 mg 4 times a day and they didn't give it to her. She was just having a terrible time, sweating, shaking, not sleeping good, and having just an awful time of it. Her pain was worse, and she wouldn't let them do things to her. I tried telling them, but they wouldn't listen. She has taken this medication for years now. During an interview on 6/15/2025 at 1:30 PM, Resident #7 stated, I was feeling awful, in so much pain, sweating, aching all over and just couldn't do anything because I felt so awful. I asked everyday about my medication, and they just told me it wasn't here. I felt awful, I think I was more anxious, couldn't sleep right, was sweaty and miserable. I did start feeling better after I got the medication. It came and I think it was four days before they got it, but I can't say for sure now. It was the one nurse here for a few days, she just kept saying pharmacy hadn't sent it. I don't know why they didn't have it. Then one day they told me the doctor needed to order it, but I was taking it in the hospital. I know I have a lot of broken bones, but when I didn't get the medicine, I feel like I was in a lot more pain, everything hurt worse. I asked every nurse when they gave medicine where it was and how long before it got here, none of them could say. I don't understand why they didn't get the medicine. I don't understand why the pharmacy doesn't deliver medicine faster. They should have made sure the prescription was there when I first got here. I can't understand why they [the nurses] didn't call for the prescription sooner, why did it take so long. I asked every time a nurse came in if my medicine was here yet. They did not care or really listen to me. They should make sure that medicine is here when someone is admitted . We told the nurses every day. During an interview on 6/15/2025 at 1:58 PM, the Director of Nursing (DON) stated, It is a standard of care that nurses call the doctors and let them know that medications are not available to administer. The staff should have called the doctor and documented that in the chart. The 9 chart code is other/see nurses notes. There are no notes in the chart telling me why the [Alprazolam] wasn't given. I don't think we have policies for med [medication] administration that state when to call the doctor, that is a standard if residents refuse or meds [medications] are not available, we give them [the physician] a call. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 6/16/2025 at 10:45 AM, the DON stated, The process is that we admit patients and fax the prescriptions to pharmacy from the hospital, sometimes they don't come with the resident, and we will need to call the doctor or nurse practitioner and have them provide a prescription to the pharmacy. This was not done for her [Resident #7], they did not call the provider until the 13th, they should have. I don't know if it is available in the EDK (Emergency Drug Kit) [also known as the automated medication dispensing system]. During an observation on 6/16/2025 at 10:45 AM, with the DON and the Administrator of the supply room where the automated medication dispensing machine was located, there was a printed handout that provided a list of all medications that were available to be taken from the machine. On page one of the document titled, [the name of the automated medication dispensing system] inventory is Alprazolam 0.25 mg Par [periodic automatic replenishment] 20. During an interview on 6/16/2025 at 10:45 AM, the DON stated, Well, the [Alprazolam] were in the [name of the automated medication dispensing system] and we should have been able to call the provider, get a script (prescription) and then call pharmacy for the code to administer the medication. The [Alprazolam] were available the entire time she [Resident #7] went without them. I guess the nurses did not know they were available for them [Residents #7, #9, and #10]. Each nurse should have called the doctor or nurse practitioner, asked them to get a script to pharmacy and asked pharmacy to let them get the med (medication) from the [name of the automated medication dispensing system]. I guess they all need training on everything that's available in it [the automated medication dispensing system]. I was not aware that this was happening, none of the nurses came to me or a supervisor and let them know about this. It is a professional standard of practice to notify a doctor when medication can't be administered. I will have to check, but I don't think anyone documented that they did any type of notification to a doctor or nurse practitioner. During an interview on 6/16/25 at 11:30 AM, Staff A, LPN stated, I called [the pharmacy] on the 13th to get her [Resident #7] medication. I didn't know that Xanax [Alprazolam] was available in the machine at that time. We are supposed to notify the doctor when we are unable to administer any medications. We need to let the doctor know with one missed dose. I did not call the doctor or nurse practitioner. I didn't know what was in the machine [the automated medication dispensing system] or that narcotics were in there. When we don't have a medicine we need to get a script (prescription) and call the pharmacy to get an authorization code to get the medicine. She didn't complain about anything to me except not having the medicine for a few days. Her husband was there [on 6/13] and he did say, she needs it she takes it all the time and she's hurting without it. I explained that I needed to get the prescription from the doctor and there wasn't anything I could do until I got the prescription and sent it. I feel badly; I really don't know anything about the withdrawal symptoms. I don't think that [what is available in the automated medication dispensing system] was covered when I oriented. I don't think they went over what was in the machine [the automated medication dispensing system].I did not document in the progress notes that I couldn't administer the medication. I really should have done that. I did not call pharmacy every day or with every dose she missed, I should have. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hawthorne Center for Rehabilitation and Healing Of	4100 SW 33rd Ave Ocala, FL 34474

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 6/16/2025 at 1:30 PM, the APRN stated, I was called on I think it was the 13th for a prescription for her [Resident #7] Xanax (Alprazolam). I can't tell you exactly when she [the nurse] contacted me. I think that some of the problems are the hospitals sometimes don't send prescriptions with the patients when they get discharged . I do think I should have been contacted for both of the patients [Resident #7 and #9] when they couldn't administer the medications when ordered. [Resident #7's name] has taken 1 mg of Xanax for a long time. She could have had withdrawal symptoms starting within the 24 hours, irritability, sweating, sleeplessness, heightening pain and discomfort. There absolutely is the risk of withdrawal with abrupt stopping of benzodiazepines [a class of central nervous system depressants used to treat anxiety, insomnia and seizures]. She would likely, most people would likely, begin to feel the effects within 24 hours and it would worsen. There is a likelihood of a seizure. It would be harmful for anyone who was on benzodiazepines to suffer withdrawal when they aren't administered the medication and abruptly stopped. They should have called me. I would have provided the pharmacy with the script. I would not know what is in the [name of the automated medication dispensing system], but if Xanax is in it I could have provided a script for a limited number of doses until the correct dose was available from pharmacy. I would say that anyone could possibly suffer harm from this [not being administered Alprazolam]. I do expect to be notified if nursing can't administer ordered medications, if vitals are abnormal and meds don't have parameters. I want to be notified with any changes in the resident's condition. This is a problem that nurses are not aware of what is available to them and what they need to do. During an interview on 6/17/2025 at 7:10 AM, Staff B, LPN stated, I took care of [Resident #7's name] and did not have the medication to administer on the night of her admission. I was waiting on the medication to get here. I can't remember but I think I called pharmacy that night and they said they were working on getting her meds (medications) in. I have been a nurse for a long time, and I know each place has an EDK [Emergency Drug Kit], whether it's a [name of the automated medication dispensing system] or a box. But I didn't realize we should call and get another one-time order for the medication. I should have done that. I didn't know that we could get the Xanax [Alprazolam]. I did not get any orders and did not call the pharmacy or the nurse practitioner. During an interview on 6/17/2025 at 7:30 AM, Staff C, LPN stated, I did not do any medication orders for her [Resident #7], that was completed by another staff, [Staff E, LPN's name], on the day she was admitted . I got involved when my father [Staff C is Resident #7's daughter] came and told me she still didn't have her medication. He told me this every day and finally on the 13th I found out it was because she didn't have a prescription with the pharmacy, and I called [APRN's name] and got that taken care of. She [Resident #7] has been taking this medication for at least eight years now, at that dose and really she is dependent on it. I do think she [Resident #7] was experiencing withdrawal symptoms. Finally on the 13th at some time she finally got the medicine. I don't take direct care of her ever and I try not to interfere with her [Resident #7] care, but I needed to make sure she had her medicine. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 6/17/2025 at 8:47 AM, the Registered Pharmacist, RPhD [doctorate] stated, We receive orders and e [electronic] scripts daily for all residents from this facility. All prescribers have access to Escribe [an electronic record to prescribe medications electronically] and can send orders at any time of the day and night. Typically, medications will go out at 2 PM and 2 AM but the facilities can ask for a stat [Latin word STATim which translates to immediately] run at any time. If the orders are received prior to 1-1:30 PM, they will go out with the afternoon run and will be at the facility between 5-7 PM depending on traffic and if received prior to 1:30 AM, it would arrive between 5-7 AM. We do have Alprazolam on PAR (periodic automatic replacement) in the [name of the automated medication dispensing system]. I can't say for sure, but I think it's a PAR of 20 at all times. I would say there is a huge problem if this medication is stopped abruptly, a large risk of withdrawal, this would begin with 16-24 hours after the last dose and would continue up to 5-10 days and with extended use, people can have a longer more extensive withdrawal time. Most commonly people develop nausea, vomiting, restlessness, irritability, agitation sleep disturbances, shakes and tremors. The most severe would be seizures and that generally occurs with higher doses at longer duration of exposure. At 1 mg four times a day it is likely that the patient began to experience one or more of these symptoms. I would say that withdrawal is not physically or mentally comfortable. The medication was always available to be administered to the patient until her medication arrived had someone called and notified us that she did not have the medication. We could have told them that we needed the prescription before the 13th. During an interview on 6/17/2025 at 9:11 AM, Staff D, LPN stated, I didn't realize that we could pull the medicine from the machine [the automated medication dispensing system]. I didn't know it [Alprazolam] was in there. I just thought it was like antibiotics and things like that. I should have asked someone about it. I should have called the doctor to get more orders, and I didn't. During an interview on 6/17/2025 at 9:50 AM, the Medical Director stated, I am the Medical Director and have been notified of the concerns that you have brought. I understand this impacted three residents, one taking Xanax once a day, one twice a day, and one four times a day. We do have some concerns with really newly admitted patients not coming with prescriptions for medications and here with some on-call providers not being able to escribe meds. But as Medical Director I am always available. There would be concerns with stopping this [Alprazolam] for long periods of time. We have more problems with opioids and returning patients to hospital because they have not come with a prescription and a provider who doesn't want to prescribe without first seeing the patient. I think this was caused when the nurses did not know that it [Alprazolam] was available and is always available. I am not their doctor so I can't really say if it would have caused any harm. During an interview on 6/17/2025 at 11:17 AM Staff E, LPN stated, I didn't actually do anything with [Resident #7's name] except fax the orders to pharmacy. I didn't see a prescription for the Xanax [Alprazolam] and the nurse coming on, I told that to her. I told her that I didn't do that [send the order for Xanax [Alprazolam]]. I did not call the nurse practitioner for the prescription. I did not know that the medication was in the [name of the automated dispensing system] machine. I don't remember any training on that. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 6/17/2025 at 3:05 PM, the DON stated, I should have been more involved and made sure that the nurses were aware of the process. I handed this to the Educator, who no longer works here, and I should have made sure that all staff were trained. It is my responsibility. No one told me that anyone had concerns about their medications. I do not audit medication administration. I just wasn't aware that this was a concern. I do expect all staff to follow doctor's orders for medications and call when they cannot give the med [medication]. Staff should all know what medications are available to them in the [name of the automated medication dispensing system]. During an interview on 6/17/2025 at 3:30 PM, the Administrator stated, Well, I would have to defer any nursing questions to the Director of Nursing, I am not clinical. Ultimately, I do expect staff to follow the policies and procedures for medication administration and any other we have. Review of the policy and procedure titled Medication Administration General Guidelines last approval date of 01/2025 read, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling and administration). The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions. Procedure: A. Preparation . 11.) If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (e.g.,) are searched , if possible. If the medication cannot be located after further investigation, the pharmacy is contacted or medication removed from the night box/emergency kit. B. Administration .2) Medications are administered in accordance with written orders of the prescriber 6) Medications are administered without unnecessary interruptions. D. Documentation (including electronic) .6) If a dose of regularly scheduled medication is withheld, refused, not available or given at a time other than the scheduled time (e.g., the resident is not in the facility at scheduled dose time, or a starter dose of an antibiotic is needed), the space provided in [name of clinical software] is coded with appropriate code. An explanatory note is entered in nurses notes/progress note. If a dose of vital medication are withheld, refused, or not available the physician is notified. Nursing documents the notification and physician response. The Immediate Jeopardy (IJ) was removed onsite on June 17,2025 after the receipt of an acceptable IJ removal plan. The facility has completed the following steps to remove the immediate jeopardy. On June 17, 2025, an Ad Hoc [Latin meaning 'for this'] QAPI [Quality Assurance and Performance Improvement] was completed in the presence of the Nursing Home Administrator, the Director of Nursing, and the Medical Director to identify the root cause analysis. It was determined that the facility failed to ensure residents were free from medication errors and missed controlled prescription medications when facili[TRUNCATED]

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interviews, record reviews and policy and procedure review, the facility failed to maintain a complete and accurate medical record when it failed to document within the medical record the reason medications were not administered for three of three residents reviewed for medication administration (Residents #7,#9 and #10). Findings include: Review of the admission record for Resident #9 documented an admission date of 5/20/2025 with medical diagnoses that include anxiety disorder unspecified, depression unspecified, essential (primary) hypertension (high blood pressure), unspecified fracture of right pubis (break in the bone of the pelvis) subsequent encounter for fracture with routine healing, fall on same level from slipping tripping and stumbling without subsequent striking against object subsequent encounter, gastroesophageal reflux disease without esophagitis, and chronic obstructive pulmonary disease unspecified. Review of Resident #9's physician orders dated 5/20/2025 read, Alprazolam Oral Tablet 0.5 MG (milligram) Give 1 tablet by mouth in the morning for anxiety. Review of Resident #9's May medication administration record (MAR) on 5/21, 5/22 and 5/23/2025 Alprazolam was documented as 9 [chart code for other/see nurses notes]. Review of Resident #9's progress notes from 5/20/2025 through 5/23/2025, documented no progress notes related to Alprazolam and no notification to the physician that the medication was unavailable. During an interview on 6/16/2025 at 11:30 AM, Staff A, Licensed Practical Nurse (LPN) stated, I did take care of [Resident #9's name] and I did not give her the Alprazolam on 5/23, it wasn't in yet. I did not document why. We should document in the progress notes or on the MAR that we don't have the med (medication) and we called the doctor. During an interview on 6/17/2025 at 7:30 AM, Staff C, LPN stated, I did not give her [Resident #9] her Alprazolam, it was ordered, and a prescription had been sent to pharmacy, so we were just waiting for it to get in. I did not write a note about why I didn't give the med; I should have. 2. Review of the admission Record for Resident #10 documented an admission date of 8/27/2024 with medical diagnoses that include chronic obstructive pulmonary disease unspecified, major depressive disorder recurrent unspecified, peripheral vascular disease (reduced circulation of blood to a body part) unspecified, atherosclerotic heart disease of native coronary arteries (heart disease) without angina pectoris (chest pain), essential (primary) hypertension, anxiety disorder unspecified, and other chronic pain. Review of Resident #10's physician orders dated 5/26/2025 read, Alprazolam Oral Tablet 0.5 MG Give 1 tablet by mouth every 12 hours for Anxiety. Review of Resident #10's May MAR, Alprazolam was documented as 9 [chart code for other/ see nurses notes] for 5/31/2025 at 2100 [9:00 PM]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #10's June MAR, Alprazolam 0.5 mg was documented as 9 [chart code other see nurses] for 6/1/2025 at 0900 [9:00 AM] and 2100 [9:00 PM]. Review of Resident #10's progress notes from 5/31/2025 through 6/4/2025, documented no progress notes related to Alprazolam and no notification to the physician that the medication was unavailable. During an interview on 6/17/2025 at 7:30 AM, Staff C, LPN stated, I did not give [Resident #10's name] her Alprazolam. I did not write a note about why I didn't give the med; I should have. 3. Review of the admission Record for Resident #7 documented an admission date of 6/11/2025 with medical diagnoses that include fracture of superior rim of right pubis, subsequent encounter for fracture with routine healing, unspecified fracture of sacrum, subsequent encounter for fracture with routine healing, unstable burst fracture of T5-T6 [thoracic, upper back between the neck and lumbar spine] vertebra, subsequent encounter for fracture with routine healing, unspecified injury of head, subsequent encounter, unspecified fracture of T11-T12 vertebra, chronic obstructive pulmonary disease with (acute) exacerbation, peripheral vascular disease, unspecified, age-related osteoporosis without current pathological fracture, chronic systolic (congestive) heart failure, unspecified osteoarthritis, unspecified site, acute and chronic respiratory failure with hypoxia, hypothyroidism, unspecified, displaced fracture of base of neck of right femur, subsequent encounter for closed fracture with routine healing, diverticulitis of both small and large intestine without perforation or abscess without bleeding, nondisplaced comminuted [type of bone fracture where the bone breaks in three or more pieces] fracture of shaft of humerus, right arm, subsequent encounter for fracture with routine healing, essential (primary) hypertension, atherosclerotic heart disease of native coronary artery without angina pectoris, unspecified fracture of unspecified thoracic vertebra, sequela, unspecified fracture of first lumbar vertebra, sequela, hyperlipidemia, unspecified, iron deficiency anemia secondary to blood loss (chronic), personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits, anxiety disorder, unspecified, personal history of other venous thrombosis and embolism, and chronic atrial fibrillation, unspecified. Review of Resident #7's physician orders dated 6/11/2025 read, Alprazolam Oral Tablet 1 MG Give 1 tablet by mouth four times a day for anxiety. Review of Resident #7's June MAR Alprazolam 1 mg documented as 9 [chart code other/see nurses notes] on 6/11/2025 at 1700 [5:00PM], 2100 [9:00 PM], on 6/12/2025 at 0900, 1200, 1700 [5:00 PM] and 2100 [9:00 PM], on 6/13/2025 at 0900, 1200, and 1700. Review of Resident #7's progress notes from 6/11/2025 through 6/14/2025, documented no progress notes related to Alprazolam and no notification to the physician that the medication was unavailable. During an interview on 6/15/2025 at 1:58 PM, the Director of Nursing (DON) stated, The staff should have called the doctor and documented that in the chart. The 9 chart code is other/see nurses notes. There are no notes in the chart telling me why the [Alprazolam] wasn't given. During an interview on 6/16/25 at 11:30 AM, Staff A, LPN stated, I called [the pharmacy] on the 13th to get her [Resident #7] medication. I did not document in the progress notes that I couldn't administer the medication. I really should have done that. (continued on next page)

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